Decision making under uncertainty in child protection: creating a just and learning culture

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Abstract

The argument is made for having a positive error culture in child protection to improve decision making and risk management. This requires organizations to accept that mistakes are likely and to treat them as opportunities for learning and improving. In contrast, in many organizations, a punitive reaction to errors leads to workers hiding them and developing a defensive approach to their practice with children and families. The safety management literature has shown how human error is generally not simply due to a 'bad apple' but made more or less likely by the work context that helps or hinders good performance. Improving safety requires learning about the weaknesses in the organization that contribute to poor performance. To create a learning culture, people need to feel that when they talk about mistakes or weak practice there will be a constructive from their organization. One aspect of reducing the blame culture is to develop a shared understanding of how practice will be judged and how those appraising practice will avoid the hindsight bias. To facilitate a positive error culture, a set of risk principles are presented that offer a set of criteria by which practice should be appraised.

Introduction

We need a positive error culture in child protection. This does not mean feeling positive when errors occur but understanding that they are likely to occur and taking their occurrence as an opportunity to learn and improve. Child protection services as

complex, adaptive systems need feedback on how they are functioning and this requires a workforce who feel able to provide feedback and senior managers who will listen and respond. For many working in child protection, such a culture seems the opposite of the anxious, defensive culture in which they operate where errors are associated primarily with blame.

'Error' in child protection work covers two significantly different types of mistakes. First, there are mistakes that are avoidable in the sense that we know in principle how the actions can be done correctly. A child protection worker may make an error in not following procedures though knowing how to do so. This may be unintentional or the worker may have decided that the deviation was the best course of action in the circumstances. The second type of error is where a decision is made about what is most likely to happen but, in fact, the less likely option transpires. On balance, a child protection worker decides it is in the child's best interest to stay with the birth family but the child later suffers serious harm or death. That is, the action is followed by an adverse, unwanted consequence.

For both these categories, a positive error culture can help us to learn how we can better protect children from maltreatment. This article begins with a discussion of how the first type of error – the seemingly avoidable type –occurs. Drawing on the safety management literature from other high risk sectors, the tendency to blame the individual is critiqued. The second type of error that arises from the unavoidable uncertainty in the work is explored in relation to the limits of risk management. This discussion identifies the importance and difficulty of creating a just culture in which workers know they will be judged by reasonable standards. A set of 'risk principles' -

standards by which decision making can be judged - are then presented for discussion as a contribution towards creating a more positive learning culture. These principles draw extensively on work done by the College of Policing in the UK (ACPO, 2011) who were dealing with similar problems of defensive practice in a blame culture. They have however been substantially discussed and tested with social workers and subsequently modified to fit child protection work.

The Causes of Human Error

Investigations into accidents and disasters have led to deeper understanding of human performance at work and of how both errors and good practice can occur. The first reviews of plane crashes or surgical errors tended to focus on technical flaws and individual actions, and conclude by blaming human error in 70-80% of cases (Wright *et al.*, 1991; Boeing Product Safety Organization, 1993) This led to recommendations on how to avoid error that were directed at individuals with three main strategies being psychological pressure to perform better, more proceduralisation or automation to reduce individual autonomy (and hence the possibility of human error) and more monitoring to check compliance with procedures (Woods *et al.*, 2010). While this approach led to useful improvement, it was found to be insufficient and to introduce new sources of error. For example, installing an alarm system to warn of a technical malfunction can be counterproductive when, in a crisis, multiple alarms go off so workers are unable to interpret them. This 'alarm overload' happened in the control room in the Three Mile Island nuclear power plant disaster when the system almost went into catastrophic meltdown (Wildavsky, 1988).

An alternative, systems approach has been developed that takes human error as the start of a further investigation not the conclusion: why did the person act that way? Woods et al (2010) differentiate the 'first story' about what happened from the 'second story' of why it happened. If we hear only the first story, we tend to be strongly influenced by hindsight bias, looking back at the sequence of events, identifying points at which a different action by a worker would have altered the sequence (if only X then …) and over-estimating how obvious this different option would have looked at the time (Fischhoff, 1982). The worker is then blamed.

However, the options looked very different before the tragedy when the worker could see several ways in which the future might unfold as well as being constrained by the conflicting demands and complexities around them (Reason, 2004; Woods *et al.*, 2010). Errors tend to arise not from the actions of one bad apple – an incompetent or dishonest worker – but from the interaction of many factors within the organisation as well as the individual. Studies reveal how the individual worker is only one causal factor in a complex social and technological network in which there may be many 'latent conditions' for error – systemic factors that make error more likely (Reason, 2000). For example, in the case of Victoria Climbie (Laming, 2003), the social worker failed to read a medical report completely and so failed to notice comments on suspected abuse. The report had been faxed to her office but the fax machine had, for some time, needed servicing and so produced smudged documents that were hard to read. The organizational failure to keep equipment in good order was a latent condition that contributed to some extent to the worker's failure to read beyond the first page of the doctor's report.

The systems approach is now not only used for accident investigations but also underpins the interest in developing learning organisations that can pick up evidence of 'latent conditions for error' and reduce them before anything major goes wrong (Department of Health, 2000; National Academy of Sciences, 2000).

When errors are blamed on one person, the organization fails to explore what other factors contributed to it and so fails to reduce the chances of other workers, in similar circumstances, repeating it.

Suppose, for example, a team develops a local custom of managing time pressures by taking shortcuts in following the procedure manual. If, in one case, this leads to the omission of an action that would have made a significant difference to protecting a child, blaming the worker in the case can be emotionally satisfying - 'if only s/he had followed procedures, the child would be safe'. But it fails to pick up that, because of the team culture, the omission will be happening in many other cases and so the conditions for future error still exist. It also fails to address the underlying problem which the workers are trying to solve by using a shortcut, ie. having insufficient time to follow all procedures.

Moreover, a narrowly focused response to error leads to narrowly focused solutions to the identified problems. The individual solutions then interact in ways that have unintended and unexpected results, as illustrated in a review of the English child protection system (Munro, 2011).

Organizations that achieve a high safety record (known as high reliability organizations) (Weick, 1987) have in common that they appreciate how error is unavoidable and that achieving safer practice requires organizations to be able to learn how the system is functioning in practice. This requires a positive error culture where people are not afraid to report difficulties, mistakes and weaknesses in their practice. Moving to such a learning culture requires a shift in how child protection organizations conceptualise good and bad performance.

The Reality of Uncertainty

Before exploring the concept of a learning culture further, let us turn to the second type of error in child protection: that caused by uncertainty. The key problem with uncertainty is that it is unavoidable. We cannot eliminate it from child protection work only reduce it and seek to manage it intelligently. It pervades our knowledge of what has happened as well as what will happen.

However thorough the investigation into an allegation of harm, there is always some degree of uncertainty about what has been happening to the child. The history collected will be incomplete. Facts are often unclear or disputed: was the father drunk at the time? Did the child fall or was he pushed? People can lie or forget. Moreover, attempting to construct a complete history would take an impossibly long time to put together. Here systemic factors will be highly influential. Workers have to make a judgment how much time can be taken to conduct an investigation relative to the urgency of a child's need for protection and the agency's resources.

When it comes to predicting what might happen to the child, the uncertainty increases. Will the parent cause further harm? Will we find a stable placement for the child where s/he develops healthily and happily? In all the key decisions that need to be made in child protection work, it is not a matter of choosing between a safe or a dangerous option. It involves weighing up and comparing the gains and the losses in, for example, the child staying at home or being in out-of-home care. In all options available, there is some probability of both harm and benefits to the child.

Predicting the future in relation to human actions is challenging because of the complexity of the causal influences on the individual.

> *The reasons it [prediction] is so difficult are the large number of variables that affect an outcome whose contributions must be both understood and measured, the role of variables we have not yet identified that contribute to the outcome, and the intervention of randomness, that is, variables that are completely outside the system but that can affect the system behaviour we are attempting to predict (Mitchell, 2009 p.88)*

The Problem of Risk

Some may be surprised that I have separated uncertainty from risk but uncertainty has always been a major feature of children's services while risk is a more recent entrant, beginning to appear in the literature in the 1980s. The terms are not synonymous. Crucially, they function differently in the social narrative. Power (1997) has graphically demonstrated how uncertainty becomes risk when someone is given responsibility for managing it. This happened in children's services over the 1980s

and 90s. Parton (1997) relates how, in England during this period, child welfare services became child protection. Nowadays, people do not generally talk of working with uncertainty but of managing risk. This shift is associated with a shift towards a blame culture in society more generally (Giddens, 1990; Beck, 1992).

The term 'risk' has also changed from its original, neutral meaning (the probability of an outcome irrespective of whether it was positive or negative) to being equated with negative outcomes. This shift means that discussions of uncertainty are often incomplete with attention to the negative possibilities not being balanced by attention to the positive ones

The shift to risk management has positive features. It draws on developments in other fields, especially probability theory, to bring some structure to the challenging task of making decisions under conditions of uncertainty. Nothing in this article should be interpreted as wanting to reject the whole concept of risk management. However, it also has negative features in that societies can all too readily expect more from it than it can deliver. With this changing social mandate '*accidents are no longer accidents at all. They are failures in risk management*'(Dekker, 2007 p.x). Hence, in child protection work, it can become the norm to react to a child's death from maltreatment by looking for the professional to blame.

The readiness with which people will blur managing risk with eliminating risk can be partly understood as arising from the human yearning for certainty and tendency to ignore uncertainty (Gigerenzer, 2015) Slovic (2010)reports how this leads people to deny the uncertainty either by making it seem so small that it can be safely ignored or

so large that it clearly should be avoided. But this sets impossible standards for child protection services. The move from conceptualizing the task as 'working with uncertainty' to 'managing risk' has itself added to another source of risk to the sector – the risk of blame. '

The child protection sector is often described as 'risk averse'. This is a misnomer. It is more accurate to say it is 'risk-to-self averse' but avoiding harm to oneself (usually in the form of blame) does not eliminate risk - it displaces it because we are not generally choosing between wholly safe or dangerous options. Sometimes the risk is displaced onto the child and family by, for example, removing the child 'just in case', or onto other professionals by referring the case on to them. This can lead to high levels of referrals to child protection services and a high level of cases being categorized as 'no further action', putting pressure on the service and subjecting families to the distressing experience of being investigated.

Being 'risk-to-self averse' can also contribute to people having undue confidence in the results of actuarial risk assessment instruments, allowing the tool to make the hard decision for them and therefore avoiding being responsible for it. In many decision scenarios, actuarial tools using algorithms have been shown to be more accurate that professional judgment (Grove *et al.*, 2000; Ægisdóttir *et al.*, 2006). However, there are a number of reasons for being cautious about their use in child protection. First, it is important to remember that these are based on data about cases referred to child protection services and there is evidence that these are a non-representative sample. Research on the incidence of maltreatment that questions adult survivors reveals a far higher rate than is known to official services and the population revealed in such

studies is less skewed towards low income and ethnic minority families (May-Chahal and Cawson, 2005; Gilbert *et al.*, 2008). Secondly, creating an algorithm from the administrative databases of child protection services incorporates any existing biases in professionals' judgments. Bias on the basis of social group, ethnicity or gender is then out of sight in an apparently neutral scientific instrument (O'Neill, 2016). Instruments are typically re-calibrated against subsequent datasets produced by using the instrument and biases can then be magnified. A 'rachet effect' where such biases get bigger has been found in the criminal justice system when such algorithms are used (Harcourt, 2008). There is no reason for assuming that child protection would avoid similar distortions and, indeed, in view of the bias in which families are reported to child protection there are good reasons for assuming that such distortions exist in actuarial tools.

Organisational Cultures about Uncertainty

A number of different organizational cultures have been identified about how to manage uncertainty and respond to errors. Westrum (1993) identified 3 types of organizational culture that shapes the way people respond to evidence of problems.

1. *Pathological culture – suppresses warnings and minority opinions, responsibility is avoided and new ideas actively discouraged. Bearers of bad news are 'shot', failures are punished or covered up.*
2. *Bureaucratic culture – information is acknowledged but not dealt with. Responsibility is compartmentalized. Messengers are typically ignored*

because new ideas are seen as problematic. People are not encouraged to participate in improvement efforts.

3. *Generative culture – is able to make use of information, observations or ideas wherever they exist in the system, without regard to the location or status of the person or group having such information, observations or ideas. Whistleblowers and other messengers are trained, encouraged and rewarded.*

Unfortunately, too many child protection agencies fit the first category of a pathological culture where fear of blame encourages workers at all levels to adopt defensive strategies and try to cover up mistakes instead of using them as the opportunity for valuable learning. In such a negative error culture, their professional practice can also be distorted by believing that they are more likely to be blamed for failures of compliance with procedures than for poor quality work with families. This creates obstacles to learning how best to provide high quality work within the constraints of the organization's resources and regulations. In England, there was also evidence that the blame culture contributed to people avoiding using their professional judgment by over-interpreting guidance as fixed rules (Munro, 2011).

If child protection services are to be able to learn from the two types of error I have discussed, they need to develop a generative culture that seeks feedback on how the system is working and learns from it. Creating such a culture requires several factors, summarized in a Department of Health (2001) report as (1) a reporting culture where people are prepared to talk about errors or weak practice; (2) a just culture – an atmosphere of trust where there is a clear line between acceptable and unacceptable behavior; (3) a flexible culture that respects the skills and abilities of front line staff

and allows them to have some autonomy; (4) a learning culture – the willingness and competence to learn from feedback and to implement reforms where needed.

While all four factors are necessary, this article is concerned primarily with creating a just culture where people feel they will be judged by reasonable standards that take account of what was known at the time rather than being distorted by hindsight. Fear of blame has been found to be a major obstacle to developing a learning culture in other sectors (Dekker, 2007). In the health sector, for example, Armstrong et al's (2018) research found that efforts to improve safety through getting feedback about errors and weaknesses in practice were undermined by the underlying blame culture: the workforce's fear of blame contributed to incorrect use of the measurement tool:

> participants largely saw the NHS-ST [the measuring tool] as a way not of taking the temperature of their organisations and using it to improve care, but as a way of distributing heat – the potential for blame' (Armstrong *et al.*, 2018 p.160)

Developing a 'clear line between acceptable and unacceptable behaviour' as the Department of Health prescribe requires tackling the difficult task of defining standards and the criteria by which performance should be judged. Procedures and guidance in child protection work provide some shared understanding but have insufficient detail; implementing them requires the individual worker's expertise and judgment and this is done within a work context that influences their performance. Time, resources and supervision all influence the standard of work in positive or negative ways.

For centuries, philosophers have studied how people do and should deliberate producing guidance but no definitive rules (Thiele, 2006). Deliberation is not just reasoning carefully but is thinking that addresses a decision or action, i.e. it is basic to child protection work. It differs from deductive reasoning in that there are no proven standards which lead to determinate conclusions. Two intelligent, well-motivated people may deliberate to different conclusions. Yet this does not mean that 'anything goes'. We have some shared understanding of what is reasonable or not in reaching a conclusion and it is this understanding that the risk principles discussed below are attempting to formulate.

They are developed from work done by the College of Policing (ACPO, 2011) who faced similar problems to child protection of wanting to tackle a risk-averse, defensive culture in which rule-following was more appealing than using initiative and judgment. They consulted with psychologists, criminologists, philosophers and police officers and, through consensus, produced a set of principles. The set below has been adapted to fit the child protection context, based on discussion with several groups of social workers. It is not offered as a definitive list but as a basis for discussion with the longer term aim of developing a greater professional consensus on reasonable standards of deliberation and decision making.

Risk Principles in Children's Services

Principle 1– The child's safety and well-being come first

Maintaining or achieving the safety and wellbeing of children and young people is the primary consideration in decision making.

While this may seem so obvious it hardly needs stating, it can be relegated to second place in a defensive culture where a person or group rank option A as best for the child but choose option B because it is more likely to protect them from blame: they cover their back.

Principle 2 –Decisions have to be made in conditions of uncertainty

Making decisions is an essential responsibility in children's services. Reluctance to do so can be harmful to children as their cases drift. A judgment has to be made about whether to seek further information to help you decide but this has to be weighed against the needs of the child and family. Drift can leave a child in danger or in an insecure placement. It can also have adverse effects on families who are anxiously waiting to hear what is going to happen.

Faced with a difficult decision, it is tempting to wait for more information to help you but, in child protection work, timeliness relative to the child's needs matters so delaying in order to undertake more investigation may be detrimental.

Principle 3 – Harm and benefits have to be balanced

Making decisions in conditions of uncertainty involves judgment, values and balance in appraising the different options available (including the option of deciding not to act). Decision makers are required to consider the value and likelihood of the

possible benefits of these different options against the likelihood and seriousness of the possible harms and then weigh up which option, overall, looks best for a child or young person. A classic scenario is weighing up the dangers and benefits for a child of staying at home and the equivalent dangers and benefits of being removed to an alternative placement.

In the event of subsequent scrutiny, they should be prepared to give an account of how they came to their decision, i.e. to be accountable.

Risk assessment necessarily involves value judgments when assessing the importance or seriousness of different outcomes (e.g. the value of staying in the birth family versus the value of greater safety in a foster care). Professionals can legitimately disagree on these topics but should try not to impose personal opinions by using professional values whenever possible.

The seriousness of an outcome should be determined by examining both its gravity (value) and its likelihood. Some outcomes are highly likely but have low gravity (e.g. minor neglect); others may be unlikely but have very high gravity (e.g. death from physical abuse).

In the face of uncertainty, the aim is to think clearly and rigorously to obtain the best possible picture without pretending that full details can ever be known.

Greater effort should be made when the decisions involve greater likelihood of harm. This approach enables efforts to be focused on the biggest dangers and takes account

of the need for proportionate, cost effective and practical responses.

Principle 4 – Judge practice by the quality of decision making not the outcome

When deciding what is in the best interest of the child, the option that, at the time, looked the safest –the most likely to have good consequences - for a child may turn out to be unsafe. Unlikely events happen. Even when all the right and appropriate care has been taken, injuries and deaths may still occur.

Rather than focusing on the outcome, assessments of decisions should concentrate on whether they were reasonable and appropriate for the circumstances existing at the time. If they were, the decision maker should not be blamed for a poor outcome.

Principle 5 – Take account of the context in which decisions are made

Those appraising decisions need to take into account the circumstances in which they were made.

Hindsight bias can seriously affect people's appraisal of a decision when it is followed by an adverse outcome but the quality of decisions is inevitably affected by the many influences that decision makers are subjected to. When a decision is being reviewed, the full conditions and influences existing at the time should be identified and examined to determine whether the action taken was reasonable in those circumstances. Implementing this principle provides a rich source of learning about how the organization is functioning and identifying strengths as well as areas of weakness.

Decisions involving some uncertainty do not occur in a vacuum. Influences on them include:

- The dynamic nature of dangers and strengths in the environment – they are seldom static. Situations alter, sometimes undergoing rapid and frequent change. Constant monitoring can be helpful but needs to be balanced against possible harmful effects on the family and the resources available.
- Previous decisions – it is unfair to take a risk decision out of the context of those that preceded it, as they will have formed part of the reasoning that went into the final action taken.
- Organisational factors – factors to be taken into account include the availability of resources, the effect of time constraints, the existence of suitable policies and processes, access to effective information systems, the effects of workload and shift work, the example set by managers, the nature and extent of supervision and the effects of the organisational culture. A positive or negative attitude to error is one such cultural factor.
- Personal factors – in reacting to and managing a situation involving uncertainty, a decision maker is influenced by many personal factors including their own knowledge, experience, skills, characteristics, values, preferences and emotions. The availability and quality of supervision is relevant here.
- External factors – decision making can be affected to varying degrees by factors such as knowledge of government statements and policies on child welfare, the outcomes of official reviews, and public expectations. Difficulties can be exacerbated in situations where the decision maker faces direct aggression or abuse, deals with highly-charged incidents or meets a lack of respect or cooperation from the community.

- The quality of decision making can be affected by the amount of time available to make it. Dealing with an emergency, for example, (where action cannot be delayed to obtain more information or wait for assistance) places greater demands on a decision maker than where there is time to plan ahead. The normal standards of decision making cannot be expected and, in law, are not expected though professionals are expected to act reasonably.
- There may be no harm-free options available. The decision maker may be faced with choosing between solutions, all of which have some negative consequences. Placing a child in foster care may reduce the likelihood of some harms (of abuse and neglect) but introduce the possibility of new types of harm e.g. losing meaningful relationships, failing to settle into permanent alternative care.
- Children's services are not responsible for all forms of danger to children. Professionals should consider whether it is appropriate for them to accept, or to continue to accept, responsibility for a danger when there are more appropriate agencies or methods of tackling the problem. They should not encourage the public to think automatically of them as the first or most appropriate port of call for every problem. Each agency must work with partner agencies rather than take on their responsibilities.

Principle 6 – The standard expected of an individual is that of a group of peers comparable in experience

The standard expected and required of professionals in children's services is that their decisions should be consistent with those a body of professionals of similar rank,

specialism or experience would have taken in the same circumstances. Total agreement between all professionals on the most appropriate solution is neither possible nor required.

- People have different levels of experience, knowledge and skills that inevitably affect the decisions they make.
- Similarly, all those involved in a situation containing some likelihood of harm, whether creating it, attempting to resolve it, or merely observing it, will perceive it in different ways. Recognising these differences and taking them into account is crucial in judging decisions.
- The objective is to create the conditions where good risk management practice can flourish, ie, allow professionals to identify and assess dangers and strengths, and make balanced and proportionate decisions in response to them.
- Professionals may feel that they lack the knowledge, skills or experience necessary for making particular risk decisions. That should not be considered a problem because the work involves such a diverse range of competencies. They should, provided it is safe to do so, refer the decision to someone who does have the appropriate knowledge and authority. If, of course, they or someone else might be harmed before that can occur, the professional must act in that emergency to at least contain the threat.
- Many cases will involve, or require, a sequence of decisions. This has advantages because it is easier to predict likelihood and to contain what happens over short periods. When reviewing outcomes, attention should be paid not just to the final decision but those that preceded and influenced it.
- Official documentation can help effective risk management. These kinds of

documents:

facilitate decisions

ensure legal and other requirements are met

help professionals to know what other professionals would do (although they must always think for themselves and consider the particular circumstances of their decision)

help both professional and non-professional readers to identify what current professional practice involves.

- As perceptions of a possible danger emerge or following a specific high-profile incident, policy makers and senior managers have often responded by producing new and often prescriptive rules, policies or other official documents. This has led to accusations of risk aversion, whereby the professional's attitude to risk is said to have become defensive and disproportionate, with staff relying too heavily on being told what to do rather than thinking for themselves. The courts only require professionalism. Rules, policies or guidelines should be as light as possible while still likely to achieve what is intended
- Decisions must be judged against the standard that existed at the time they were made, not the standard that may exist at the time of a review.

Principle 7 – Learn from successes as well as failures

To reduce defensive decision making, professionals need a culture that learns from successes as well as failures. Good risk assessment and decision making should be identified, recognised and shared, e.g. by conducting Appreciative Inquiries (Whitney and Cooperrider, 2011) or showcasing good practice (Stevenson, 2017).

More valuable lessons can be learned from examples of successful decisions than from the much rarer ones that lead to loss or harm.

- Most decisions have successful outcomes, and experience shows that people learn more useful lessons from what works than from what does not work.
- Rather than focus on poor decisions, therefore, (especially where harm has occurred) a risk management approach needs decision makers to have access to lessons learned and good practice.
- A selection of decisions, both those leading to benefits and to harm, should be examined openly and regularly to assist future decision makers
- As people learn more about assessing dangers and strengths, try things out and develop experience, a more positive, confident and professional attitude to managing the risk of harm should take shape.

Principle 8 – Good information sharing is key to good risk assessment

Since good decision making depends on quality information, children's services work with partner agencies and others to share relevant information about those who pose risk or those who are vulnerable to the risk of harm.

- Good quality information exchange and shared risk assessment and risk management planning between government agencies, non-government organizations, community groups and service providers is essential to managing risk effectively. This requires relevant agencies to work collaboratively in relation to people who pose a risk of harm to others, or are deemed to

- The anticipated benefits of effective information sharing can be summarised as:

    better decision making

    improved protection of individuals at risk

    reduction in crises through taking earlier effective action

    improved inter-agency working

    better assessing of individual need, risks and strengths

    more effective intervention, support and targeting of resources.

All information sharing must be conducted in accordance with relevant legal powers or duties.

Principle 9 – Encourage and support staff

Professionals in children's services who make decisions consistent with these principles should receive the encouragement, approval and support of their organisation.

Conclusion

The blame culture in child protection is frequently discussed but the aim of this article has been to explore the way it contributes to problems and how it can be reduced. Recognising how individual performance is influenced by the organizational system leads to appraisals of practice going beyond the 'first story' of what the child protection worker did or did not do to explore the 'second story' of what factors in the wider system contributed to poor or good performance. This can produce lessons that have wider relevance than the single instance for improving practice and increasing children's safety.

Recognising the causal significance of the organizational system also has implications for how we appraise the quality of practice. We may indeed find errors or weak judgments and decisions but we need to judge them in terms of how reasonable these were, taking into account all the factors of the case. The risk principles set out criteria that guide this appraisal. They recognize the nature and complexity of child protection work and acknowledge the significance of the wider system's impact on performance. By studying the context surrounding the practice, the risk of hindsight bias distorting judgment can be reduced. The conclusion of any appraisal, however, is not determined by these principles. Judgment is needed in applying them and there may be disagreement between appraisers however carefully their deliberations.

While this article is arguing for a less punitive work culture, it is not calling for a 'blame free culture' but a just culture. Willful or malicious behavior deserves blame. If someone sexually abuses a vulnerable child in out of home care, for example, they should be punished. But such instances are rare. In reviews of child deaths, there is no 'bad apple' who alone failed to protect the child. The picture of practice that is described is often of several episodes of weak practice, procedural lapses, misunderstandings. In some cases, the practice is not faulted but the review concludes that the danger to the child was not predictable; this was the case in 25% of child death reviews in one study (author's own 1999).

While acknowledging how an individual's performance is constrained and shaped by systemic factors, it is important to not to go to the other extreme of seeing people as puppets totally controlled by system. Dekker reminds us that there is : ' *discretionary space for personal accountability – a space that can only be filled by an individual*

care-giving human'' (Dekker, 2007). However, if the aim is to learn how to avoid future errors, paying attention to the organisational factors that influenced the individual is the more productive route.

In many jurisdictions, growing demand and limited funding is problematic. One popular management mantra is to be '*faster, better and cheaper'*. But evidence from other sectors strongly suggests that you can only have two of these at once (Woods *et al.*, 2010). Funding pressure can be a major source of adverse impact on performance, leading to dangerously high workloads and individuals cutting corners in their efforts to manage the demands on them. Having a culture that can learn about these weaknesses in the system is important in order to reduce the likelihood of errors that adversely affect children and their families.

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